Compliance Evaluation

John Umstead Hospital

Date of Site Visit: October 18-19, 2007

Date of Report: November 21, 2007

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Code for reading this Evaluation

C = Compliance. Hospital has substantially complied with the requirement.

SC = Significant compliance. Considerable compliance has been achieved on the key components of the requirement, but refinements remain to be completed.

PC = Partial compliance. Hospital has made reasonable gains toward being in compliance with the requirement, but substantial work remains.

NC = Not in compliance. Hospital has made inadequate progress towards being in compliance.

All four measures reflect current outcomes of Hospital's work and are neither a measure of intent nor of effort. In fact, minimal effort in one area might achieve compliance on one item while significant effort in another may still leave the Hospital rated not in compliance on that item.

Font in this Evaluation.

Italics. Items in italics represent those found to be in compliance at the time of prior evaluation.

Bold Face. Items in bold face reflect findings from this evaluation.

DATA BASE

Documents

Administration

Operating Bed Capacity
Census by Unit, September 24, 2007
Plan for Closure of John Umstead and Dorothea Dix Hospitals, May 2007
Dates Waiting List in effect, February 9-September 10, 2007
List of number of admissions per fiscal year 1999-2006
List of average daily census per fiscal year 1999-2006
Patient to Patient Assaults data for January 2001-August 2007 by month
Patient to Staff Assaults with Injury per fiscal year 1999-2006 per month
Listing of restraint hours (hospital-wide, child/adolescent and adults), July 1999-August 2007
Listing of seclusion hours (hospital-wide, child/adolescent and adults), July 2002-August 2007
Graphs of seclusion and restraint rates (child/adolescent and adults), July 2002-August 2007
List of the number of rate of major patient injuries, July 1999-July 2007
Number of patient deaths per year, 1995-2007
JUH Operating Bed Capacity, April 2007
Map, JUH
Treatment Team meeting Schedule, October 18-19, 2007
CRIPA-2007. How, What, When and Where. All your questions answered.
Annual Report of Employee Competency, July 1, 2006-June 30, 2007

Staffing

Number of separations and number of new hires/reinstatements/promotions by job classification, January 1-August 31, 2007
Psychology FTE's, Temporary Hires, September 2007
ADATC staffing: Social Work, Counselors, Rehab Therapists, Therapeutic Recreation Specialists
Nursing positions by Unit
Nursing Hours per Patient Day with Percent RN Hours per Patient Day, dates unspecified
Nursing Vacancy Report, September 2007
Physicians by Unit, September 2007
Rehab Services by Unit, September 25, 2007
Types of RN staffing (full time, TNP, Agency/Travelers, OT) by Unit, August 2007

Policies and Procedures

Behavioral Treatment Planning, October 1, 2007

Suicide Precautions, July 31, 2006
Treatment Planning and Monitoring, April 15, 2003
Seclusion, Restraint, and Other Intervention Procedures, January 17, 2005
Accounting for Patients, October 2007
PRN Psychotropic Medications, July 1, 2006
Mental Retardation/Mental Illness Assessment, October 1, 2007
Behavioral Treatment Planning, October 1, 2007
Meeting Minutes
Social Work Executive Committee, May 2, June 20, 2007
Committee Minutes
Performance Improvement/Risk Management Committee, October 10, 2007; September 26, 2007; September 12, 2007

Assessments

Psychiatric

1083807	10-2-85	9-19-07
1082440	47 year old	7-22-07
1069987	22 year old	9-14-07
1017016	4-17-62	7-16-07
1074291	4-10-59	9-11-07
1084148	5-29-41	9-25-07
1082686	11-25-50	8-1-07
0036732	12-8-58	6-21-99
1084515	19 year-old	10-10-07
0999699	5-16-76	10-9-07
1078558	44 year-old	10-10-07
1084466	9-11-66	10-8-07
1060617	11-4-88	10-9-07
1002560	7-24-77	10-5-07
1051106	1-27-68	10-8-07
0975840	7-13-60	10-12-07
1084551	47 year-old	10-11-07
1084567	46 year-old	10-11-07
1084552	54 year-old	10-11-07
1084553	37 year-old	10-12-07
1084613	47 year-old	10-12-07
0972575	38 year-old	10-12-07
1084605	7-28-92	10-12-07

(Annual) Psychiatric Assessment Update

0985267	8-14-03	July 2007
0039001	12-2-99	December 2006
0953142	10-20-04	October 2006
1046079	5-10-71	April 2007

015372	3-26-80	May 2007

Treatment Plans

1027494	4-13-07	MTP
	5-11-07	TPR
	6-29-07	T{R
	9-7-07	TPR
0040683	10-11-06	MTP
	7-11-07	TPR
1084056	9-26-07	MTP
0053373	9-28-07	MTP
0952547	6-15-07	MTP
	7-25-07	TPR
1018765	9-20-07	MTP
	9-13-07	TPR
	9-20-07	TPR
1017016	7-24-07	MTP
0043658	9-18-07	MTP
	9-25-07	TPR
LJJ	9-21-07	MTP
1082874	8-13-07	MTP
	8-27-07	TPR
0049669	7-17-07	MTP
	8-9-07	MTP
	8-29-07	TPR
1082380	9-18-07	MTP
	9-25-07	TPR
1083617	9-13-07	MTP
1066464	7-24-07	MTP
	8-14-07	TPR
0052164	9-5-07	MTP
	9-18-07	TPR
1083503	9-11-07	MTP
	9-25-07	TPR
0031801	9-18-07	MTP
	9-25-07	TPR
1081766	10-1-07	MTP
1058183	5-10-07	MTP
	5-21-07	TPR
	6-21-07	TPR
	7-19-07	TPR
1067285	9-5-07	MTP
	9-17-07	TPR
	9-17-08	

Admissions/Discharges

Admissions

0282483	dental	September 20, 2007
1083644	dental	September 7, 2007
1083625	dental	September 6, 2007
1081044	dental	August 24, 2007
1083226	dental	August 21, 2007

Letter, Ellen Holliman to Stephen Oxley, August 3, 2007

Discharge Plans for all current MR inpatients with LOS > 60 days

0021611
DP
CB, Jr.
ESJ
1081122
JME

Discharge Instruction Sheet

1083414
1055441
0911059
0046048
0966483
0610773
1083933
1083778
1083555
CS
0990018
1083876
1083661
1076803
1083807

Rehab Unit Discharges per Month, January 2004-September 2007

Critical Barriers to Discharge for Patients on rehab Unit one year or longer for 2006

Recidivism Coordinator position description

Recidivism Evaluation form

Recidivism Evaluations

0966103	10-16-07
1011873	10-15-07
0975056	10-13-07
0988129	10-12-07
0053373	10-12-07

List of Patients with 10 or more JUH Admissions

List of Patients with 3 or more JUH 2007 Admissions

Medical

List of patient deaths, January-September 2007
MSU Death Review Committee, case 1074618, September 17, 2007
PI Project Report: Medication Errors, January-June 2007
Root Cause Analysis, death case 1080260, July 23, 2007

Special Populations

List of patients dually diagnoses with mental retardation
Assessment instruments or parts thereof to screen for alcohol and substance abuse
Psychopharm orders and progress notes for last five patient admitted with Axis II diagnosis of MR

0386462	9-16-57	8-21-07
1018765	8-16-85	9-15-07
0152111	10-28-58	8-21-07
1083530	1-21-95	9-2-07
1005102	10-11-90	8-19-07

Treatment Plans: MR Patients

1081122	7-1-41	6-8-07	Moderate MR
1062756	7-25-97	6-23-07	Moderate MR
1012780	6-4-73	3-18-02	Mild-Moderate MR
1018765	5-16-85	9-15-07	Mild MR

Treatment Plans: SA Patients

1029452	10-23-64	9-11-07
1044956	1-9-67	9-18-07
1073797	2-7-87	7-10-07
1059632	7-3-83	8-23-07

See also Treatment Plans section

Medication

Benzodiazepine Medication Usage, September 28, 2007
STAT Psychiatric Medications includes physician order, MARS, progress note, August 18-31, 2007; October 14-20, 2007
Antipsychotic Medication usage by Patient, September 28, 2007
Four Admission Assessments showing rationale for medications prescribed on admission
1081766
1082477
1083147
0955704
Performance Improvement Plan: Informed Consent for psychotropic medication… April-June 2007
Performance Improvement Plan: Adverse Drug Reactions, Annual FY 2007
Performance Improvement Plan: Documented national…two or more antipsychotic medication, April-June 2007

Performance Improvement Plan: Rationales for medication changes…documented… April-June 2007
PRN Medication Orders, October 14-20, 2007

Behavioral Consultations

1063422	Psychology Services Consults	8-28-07
(adult)	Master Treatment Plan	5-29-07
0953142	Functional Assessment	7-6-07
(adult)	Behavior Support Plan	6-19-07, 7-23-07 (revised)
	Master Treatment Plan	10-23-06
1082477	Crisis Response Plan	7-31-07
(child)	Behavior Guidelines	7-31-07, 9-18-07
	Behavioral Assessment	9-18-07
	Master Treatment Plan	7-30-07
1012780	Behavioral Assessment	7-16-07
(MR)	Behavior Support Plan	7-17-07
	Procedures	7-17-07
1062756	Behavioral Assessment	7-26-07
(MR)	Behavior Support Plan	7-27-07
0155989	Behavioral Assessment	10-15-07
(adult)	Behavioral Guidelines for Staff	10-15-07
1063422	Behavioral Assessment	8-28-07
(gero)	Behavior Support Plan	9-10-07
	Behavior Plan Inservice Training	9-10 to 9-24-07
1062756	Behavioral Guidelines	10-17-07
(child/MR)		
1046079	Behavioral Assessment	10-15-07
(adult)	Interventions	10-2-07
	Behavior Plan Inservice Training	10-8 to 12-12-07
0985267	Behavioral Assessment	10-17-07
(adult)	Behavior Strategy Plan	10-18-07
	Behavior Plan Inservice Training	10-17-07
0952726	Initial Psychological Evaluation	6-27-07
(gero)	Behavioral Guidelines	undated
	Behavior Plan Inservice Training	10-16 to 10-17-07

0034742	Initial Psychological Evaluation	10-15-07
(adult)	Behavioral Guidelines	10-15-07
	Behavior Plan Inservice Training	10-16-07
JC	Initial Psychological Evaluation	5-27-07
(MR)	Behavioral Guidelines	undated
JJ	Initial Psychological Evaluation	9-24-07
(MR)	Behavioral Guidelines	10-17-07
1043663	Initial Psychological Assessment	8-2 to 8-28-07
(MR)	Behavioral Strategies	10-8-07
1083136	Behavior Plan Inservice Training	10-8 to 10-15-07
(MR)	Behavioral Assessment	undated
1068381	Initial Psychological Evaluation	9-10-07
(adult)	Behavioral Strategies	9-28-07
1083136	Plan to remove restrictive intervention	8-31-07
(child)		
1077917	Behavioral Assessment	9-26-07
(child)		
1083530	Behavioral Assessment	9-26-07
(child)		
1076803	Behavioral Assessment	9-20-07
(child)		
248295239	Behavioral Assessment	9-4-07
(adult)		

PSR

Group Progress Notes
- 5 Gero Mall
- 6 Rehab Treatment Mall

Group Rosters with goal per patient
- 1 Gero Mall
- 5 Rehab Treatment Mall

MISA group schedule
Gero Unit Active Treatment Programming Schedule
CPI Schedule, October 2007

AAU Master Calendar of Centralized programming
Work Therapy Schedule, October 2007
Ward 452: Patient Treatment Schedule
Ward 441: Women's Program Patient Treatment Schedule
Ward 453: Patient Treatment Schedule
TACT: Trauma Awareness and Calming Training Manual

Staff Training

Benzodiazepine Self Study Packet, RN's and LPN's, April 9, 2007
Benzodiazepine Post Test, April 9, 2007
Assessment and Placement for DD/MR Patients, Social Work, September 20, 2007
Master Treatment Plans: Developing Interventions, Treatment Plan Coordinators, April 4, 2007
Clinical Orientation: Behavioral Planning: Developing Effective Behavior Plans, Drs. Barrick and Elbogen, July 5, 2007
Hospital Orientation Agenda, Day 1, 2, September 5, 2007
Clinical Orientation Agenda, September 10, 2007
Dual Diagnosis: Psychiatric Illness and Substance Abuse, Social Work, May 2, 2007
Substance Abuse: Monthly Training, Social Work, July 2007

Quality Assurance/Performance Improvement

Quality Reviews – Master Treatment Plans, January 12, February 16, March 15, April 10, May 4, June 11, July 9, September 12, 2007
Performance Improvement Program Quarterly Report
July-September 2006
October-December 2006
January-March 2007
April-June 2007
Dates Waiting List in Effect, February 9, 2007-present
Graphs
Adult Admission Unit admission by month, July 2006-Juen 2007
Average Daily Census, July 2006-June 2007
Census by Day, Adult, Gero, February 2-June 29, 2007
AAU Census by Day, February 7-June 30, 2007
Gero Census by Day, February 7-June 30, 2007
Performance Improvement Program: Risk Management Plan: Patient Injuries related to patient assaults will be reduced. January-March, 2007; April-June, 2007
Performance Improvement Program: Risk Management Plan: Source of injuries… January-March, 2007
Memo, Terry Vaughn to Helen Clark, September 28, 2007
PI Committee Discussion Regarding CS Assault Rates, May 2006-May 2007, undated
Memo, Donna Dawson to Helen Clark, October 15, 2007
Performance Improvement Program: …staffing effectiveness… January-June 2007

Performance Improvement Program: Reduction in over-all use of seclusion and restraint within CPI, January-June 2007
Performance Improvement Program: Treatment Plans… April-June 2007
Performance Improvement Program Active Treatment, April-June 2007
Performance Improvement Program: Use of Seclusion… CPI and behavioral restraints… AAU, April-June 2007

Physical Plant

Description: Safety Rounds aka ENVIRO Rounds
ENVIRO Team Audit Sheets
- Patient Safety
- Life Safety
- Environment
- Bloodborne Pathogens

Environmental Rounds Reports, January-August 2007

January	ADATC
February	Building 48 (Auditorium, Rx Mall, Gym, Canteen)
	Cathell Building, WAC and VR
April	CIP
May	Admitting Office and AAU
	Gero
June	Rehab
	MSU/Pharmacy/PT/Beauty Parlor
July	ADATC
	Building 48, Camp Barham
August	Cathell Building, WAC and VR

Outside Reports

JCAHO: August 16-17, 2007
NC, DHHS, DFS, MHLCS: February 19, 2007
NC, DHHS, DFS, MHLCS: March 16, 2007
NC, DHHS, DFS, MHLCS: April 19, 2007
NC, DHHS, DFS, MHLCS: June 22, 2007

On Site

Patient Records Reviewed Onsite

1005102	10-11-90	8-19-07
1050724	12-23-80	6-28-07
00399011	7-10-58	12-2-99
1013887	1-9-52	12-18-06
0985267	12-27-83	8-14-03
1043715	1-8-75	8-21-07

1083503	8-21-64	9-1-07
1083989	4-9-72	9-20-07
0952547	3-7-59	6-7-07
0270922	12-20-55	9-26-07
0905477	6-12-88	8-31-07
0049706	4-25-50	7-1-07
0953142	11-10-46	10-20-04
1046079	5-10-71	4-12-05
0152111	10-28-58	8-21-07
005008	4-13-68	10-11-07
1006331	7-31-90	10-4-07
0992997	3-1-68	10-17-07
0053010	10-9-40	10-1-07
0015372	7-6-36	4-26-02
0033666	10-2-53	9-13-07
0043568	8-14-68	10-17-07

Treatment Teams Observed

Gero Team:	0980127	TPR
Rehab Team	1077393	TPR
Acute Team	0398667	MTP
AADTC	1084309	TPN
	108465	MTP

Groups Observed

Gero Mall		
Current Events	14 patients	4 staff
Health Forum	10 patients	3 staff
Visual Motors Group	4 patients	9 staff
Work Activity	4 patients	1 staff
CPI		
Younger Children		
School		
Classroom	5 patients	1 staff
Classroom	1 patients	1 staff
Kids in Motion	2 patients	1 staff
Computer Group (Leisure)	1 patients	1 staff
Restrictive Track Program		
Room 1 (task)	3 patients	2 staff
Room 2 (video)	2 patients	3 staff
Adolescents		
Choices	4 patients	1 staff
Problem Solving	3 patients	1 staff

Dealing with Feelings and Emotions	4 patients	1 staff
Rehab Mall		
Self Esteem	5 patients	1 staff
Treatment & Recovery	8 patients	2 staff
Leisure Awareness	11 patients	4 staff
Life Skills (Spanish)	5 patients	2 staff
12 Step	12 patients	3 staff
Work Therapy		
Piece work	17 patients	5 staff
Janitorial 1 patient	all staff	

Wards Toured

Ward 324 (Gero)
Ward 491 (CPI)
Ward 453 (ADATC)
AAU

Interviews

Stephen Oxley, Director
Lou Ann Crume, Clinical Director
Cheryl Ouimet, Director of Policy Operation
Pat Humphrey-Kloes, "Acting" Director of Nursing
Shirley Gardner, "Acting" Associate Director of Nursing
Jackie Tope, Assistant Attorney General, NC
Joanne Scott, RN, Gero Unit
Kim Newton, Gero Mall Coordinator, Associate Director PSR
Otis Lyons, Instructor, Industrial therapy, Gero
Marilyn Keith, RN, Gero Unit
Olivier Goust, Clinical director, CPI
Allison Taylor, OT Director, Work Therapy Director
Jerome Burton, Teacher (RT)
Tom Buzzard, Behavior Specialist
Robin Cohen, School Principal
Billie Wilson, RN, CPI Unit RN Director
Charlotte Murphy, Rehabilitation Unit Program Coordinator
Maurice Perry, Work Therapy Leader
Wayne Breedlove, Risk Manager
Mary Jo Alessio, RN, AAU
Sharon McDonald, ADATC program Manager
Lina Coffee, RN, ADATC
Charles Saunders, HCT
David Drovitz, Director of SW
Ginnie Pypkowsik, Recidivism Coordinator

Dr. Saxena Team (Gero): Psychiatrist, RN, Psychologist, RT, SW, HCT
Dr. Cvejin Team (Rehab): Psychiatrist, RN, Psychologist, SW, RT, HCT, PA student
Dr. Bowen Team (AAU): Psychiatrist, RT, HCT, SW, RN
Dr. Reddi Team (ADATC): Psychiatrist, RN Supervisor, Counselor x 2, RN, RT Supervisor, HCT

Exit Plans: US and NC: John Umstead Hospital (JUH)

Assessments

<table>
<tr><th>Item</th><th>Compliance</th><th>Findings</th><th>Comments and Recommendations</th></tr>
<tr>
<td>Appropriateness of the admission
Other less restrictive settings (VIIB)</td>
<td>SC</td>
<td>Admission and Average Daily Census Data Per Fiscal Year
FY 99 through 2006

<table>
<tr><th>Fiscal Year</th><th>Admissions</th><th>Avg Daily Census</th></tr>
<tr><td>1999</td><td>5383</td><td>487</td></tr>
<tr><td>2000</td><td>5643</td><td>484</td></tr>
<tr><td>2001</td><td>5569</td><td>413</td></tr>
<tr><td>2002</td><td>5689</td><td>348</td></tr>
<tr><td>2003</td><td>6002</td><td>306</td></tr>
<tr><td>2004</td><td>5812</td><td>286</td></tr>
<tr><td>2005</td><td>6055</td><td>273</td></tr>
<tr><td>2006</td><td>5810</td><td>286</td></tr>
</table>

AAU is staffed for capacity of 188 patients
July 1-31, 2006, over 118, 60 of 123 days (49%)
Oct 1-Dec 31, 2006, over 118, 24 of 92 days (25%)
Jan 1-Apr 30, 2007, over 118, 15 of 120 days (13%)
Apr 1-Jun 30, 2007, over 118, 21 of 91 days (23%)
Gero Unit is staffed for capacity of 20 patients
Apr 1-Jun 30, 2007, over 20, 84 of 91 days (92%)
JUH utilizes a wait list of AAU census reaches 110% of capacity. February 9-June 30, reached this 13 days.

See Table 1 (attached).

See Table 2 (attached).</td>
<td>The opening of CRH and subsequent closing of JUH and DDH will result in treatment and services to individuals in an improved setting. CRH, which will be located in Butner will have the same capacity and capability as JUH and DDH hospitals combined.

In order to geographically accommodate admissions to 3 instead of 4 State hospitals, a 3 Region Model is being proposed. All counties and Local Management Entities (LMEs) will continue to be served by the hospital designated for their region. Although this model will result in increased admissions to Cherry and Broughton Hospitals, plans have been developed to minimize the impact on those two hospitals.

CRH, with a 115-bed overflow unit, will have the capacity to serve the same number of individuals as are currently being serviced at both DDH and JUH. Prior to the opening of CRH, 50 forensic beds will be transferred to Broughton Hospital to serve individuals from the western half of the State. Additionally, increased utilization of R.J. Blackley Alcohol and Drug Abuse Treatment Center (ADATC) for acute substance abuse admissions from the South Central Region is expected to decrease the number of admissions to CRH.

Although the established operating capacity of the main CRH facility is 432, each unit has the ability to expand by 2 beds, resulting in the maximum capacity of 468. The total possible number of beds</td>
</tr>
</table>

			at CRH, including overflow and expansion, is 583, higher than the current combined operational beds at JUH/DDH and higher than the combined average daily census of the two hospitals. CRH, consistent with the other State-operated psychiatric hospitals, will rely on employees rather than private providers for the care and treatment of patients. The Division has determined that the regions for State facility admission would be realigned. This results in a net decrease in the total population base for the CRH of 762,519 less than currently served by JUH and DDH hospitals. No impact is anticipated on Developmental Centers or Neuro-medical Centers as a result of the closing of DDH and JUH and the opening of CRH. Development of the Recidivism Coordinator Position for JUH. The Recidivism Coordinator is focusing on: a) Coordination between LMEs and providers to obtain appropriate services; b) recommending the need for ACT programs; c) identifying payee services; d) identifying mentally retarded patients who need behavioral plans and involving Murdoch Center's Specialized Consultant services; e) working with LMEs and ACT, CST providers to refine service and crisis plans that incorporate patients' desires/needs; f) advocating for patients to receive ACT services when indigent. This is a new endeavor.
Multidisciplinary with attention to co-morbid diagnoses, i.e., MRMI and MISA (IIIA1,B1,B5)	SC	MR On 9-27-07, there were ten (10) adult patients at JUH with MR diagnoses as follows: Mild 4 Moderate 3 Severe 1 Profound 0 Unspecified 2	Increased attention to patients with dual disorders is noteworthy.

		The LOS for these patients was less than 1 year 6 1-2 years 1 3-5 years 0 greater than 5 years 3 Of those with LOS greater than 5 years forensic 2 (1-Rehab, 1-Gero ICF) civil 1 (Rehab) On 9-27-07, there were five (5) child patients at JUH with MR diagnoses as follows: Mild 2 Moderate 1 Severe 1 Rule out 1 LOS for all patients was between 3.5 and 8.5 weeks SA Screening Substance and Alcohol Abuse is specifically queried on the: 1) Psychiatric Assessment (page 1) and 2) on the Biopsychosocial Assessment (pages 2 and 3).	
Psychological identifying Suicide risk (IIIB2)	*C*	*Suicidality and/or potential for SIB, when ascertained on initial assessment, is followed up with appropriate orders for level of observation. See for example, #1077749, #1051206, #1077066, #1010638, #1076977, #1077829.*	
Self-injurious behavior risks (IIIB2)	*C*	*Falls within the penumbra of suicide risk.*	
Cognitive strengths and weaknesses (IIIB2)	*C*	*Mental status examinations are done on all admissions as part of the initial psychiatric assessment. Mental status examinations are done to monitor medication effects on cognitive functioning. Examples identified of consultations*	

		from neuropsychology when clarification of cognitive capacities required. See for example, #0038835, #1077066.	
Identify and prioritize patient needs with particular attention to "special needs" Suicide risk (IIIB4)	*C*	*There is evidence of a gradient of levels of observation used for patients who are at imminent risk for suicide or self injurious behavior. There is evidence of incorporation of suicidality and/or SIB in MTP's. There is evidence that Attending Psychiatrists monitor suicide risk and risk of SIB. See for example, #1077749, #1051206, #1010638, #1076977.* *There is evidence of evaluation of suicidality/SIB on annual assessments and on transfer between units. See for example, #1072660, #0039011, #0963153.*	
Self-injurious behaviors	*C*		
MI/MR	SC	MR Patients 5 pairs of physician orders and corresponding progress notes were reviewed – see document list under Special Populations. Medication documentation approached the standard of care, but specific improvement needs to focus on: – justification for medication in first Attending Psychiatrist note – consistently writing notes when STAT med ordered – justification for use of benzodiazepines, be they standing or prn orders	
MI/SA (IIIB2)	SC	Treatment Plans: Alcohol and Substance Abuse is appearing with greater frequency on the problem list and as a problem with goals and interventions.	

Hearing impaired (IIIB6)	*N/A*	*No deaf patient in hospital. No recent admissions of deaf patients. Deaf patients are treated at Broughton Hospital.*	
Psychopharmacological examination of appropriateness of current and ongoing pharmacological treatment for behaviors (IIID6)	*C*	*Psychopharmacologic interventions consistently show a concordance between Axis I diagnoses and medications prescribed. No evidence of psychotropic medication being used for behavioral control in persons without Axis I diagnoses.*	
Medical (VB)	*C*	*Admission history and physical exams almost uniformly done. See for example, #1077066, #1015192, #1010638, #0939104, #1077444, #1077066, #1040802, #1042089, #1077829, #0997238, #1061918. There is a question that sometimes these may be too cursorily done, see #1077829. These are important outliers to getting the admission H&PE done:* – *when patient refuses or only allows partial exam and no one goes back when mental status allows exam: #0389567. This can have potentially bad outcomes as in this case* – *when patient is uncooperative and no one goes back when mental status allow exam, #1077676* – *when patient comes from another NC state hospital, even if PE missing relevant data, #0997649* *AIMS exams are routinely done on admission; see for example, #0939104, #1077444, #1040802, #1042089, #1077829, #0982087, #1061918, #0997238, #1077066.* *Admission labs are routinely done; see for example, #0982087, #1061918, #0939104, #1077444.* *Annual reviews of medical findings are consistently found in the Annual Psychiatric*	

		Assessment. Medical coverage in these is generally excellent. For an outstanding example, see coverage of positive HIV and metabolic syndrome in #1012780. *Annual medical exams are generally done. See for example, #1012780, #0953142, #0039011. There are exceptions, however. It appears that when the medical physician does frequent (who knows how that is defined?) physical exams, he/she fails to do an annual physical exam. See for example, #1063422.* *Patients consistently have Axis III Medical Plans as part of the MTP. These appear to be updated when necessary with a reasonable degree of completion. See for example, #1063422, #076354, #0963153, #0953142. It is unclear, however, how a patient who refuses a medical history and physical exam can have an Axis III plan completed, see #0389567.* *Patients in need of medical attention beyond what can be delivered on one of the psychiatric wards can be treated in the MSU. Records of patients treated there on February 12, 2007, indicated 11 patients appropriately placed these. There is evidence for the capacity for rapid transfer of patients as evidenced by memorandum and by actual patient movement. See for example, patient transfer from CPI to MSU at 1:40 a.m. on February 11, 2007, #1077749.* *Nutrition evaluations and updates were consistently present.* Obesity not adequately addressed. See for example: 1006331 0033666	

		0043568 Deaths – 1995-2007 (Sept) Year Deaths 1995 16 1996 14 1997 13 1998 9 1999 11 2000 10 2001 6 2002 8 2003 4 2004 3 2005 2 2006 1 2007 1 See Table 3 (attached).	The number of patient deaths has declined, especially since 2002. In June 2002, JUH closed 30 ICF beds on the Geropsychiatry Unit. Additionally, as a result of downsizing over the past 4-5 years on the Geropsychiatry Unit (current capacity = 20 beds) many medically frail patients were discharged to NC Special Care Center or to nursing homes.

Treatment Plans

Item	Compliance	Findings	Comments and Recommendations
Individualized (IIIA5)	PC	Master Treatment Plans Significant improvement. Individualized problems include "recidivism"/"frequent rehospitalization" substance use/alcohol use "non-compliant behavior" "refusal of physical" "pregnancy" Sometimes problems are hard to comprehend: "odd behavior" "ineffective individual coping" (shows up in several MTP's)	Overall improvement in MTP's. Better evidence of individuation. Better evidence of "thinking" within the MTP.

		Diagnosis R/O is occasionally ruled out, often not. NOS diagnoses need to be further evaluated. Medical Improvement in terms of inclusion and planning. Obesity noted, but not addressed. Long-term and short-term goals Not clear always that goals are patient's goal. STG's often fail to be observable, measurable, countable. STG's are used that could only be known to the patient. STG's are too often only cognitive goals without behavioral goals. When STG's have time specification, sometimes unclear if performance needs to be consecutive; if behavior needs to be demonstrated only once. Stating LTG is decrease of symptoms is not useful. Interventions Teams forget that patients do not perform interventions, staff do. Interventions need to have frequency and duration per intervention. Overall integration Pieces of the MTP need to fit together. Cannot be working on a problem that does not appear on the problem list.	
Interdisciplinary (IIIA5a)	SC	Process varies greatly Team to Team. Rehab Treatment Team performed very well; Gero Team very poorly.	Target mentoring to more intense intervention for the weakest Teams.
Based on Assessment data (IIIA5a)	SC	Diagnoses on MTP not completed and no indication work-up in progress: 1005102 R/O Bipolar Affective D/O 1043715 Deferred on Axis II 0270922 Deferred on Axis II	

<table>
<tr><td></td><td></td><td>0905477 Deferred on Axis II
0953142 Possible Antisocial Traits</td><td></td></tr>
<tr><td>Attend to co-morbid diagnoses (IIIA1, B5)</td><td>C</td><td>MR
Treatment Planning for patients with Axis II diagnoses of MR has improved. Behavior Plans are integrated into the MTP. Some interventions show clear cognizance of patients' cognitive limitations. On the other hand, consultation with the Murdock was a planned intervention that did not occur for at least 2 months after it was entered on the MTP (108122). When there is only one STG for a problem and it is attained, there needs to be another STG if interventions continue (1081122). Evidence of habilitation, rather than just management, gets mixed reviews. Cognitive limitations and their impacts on the patient's functioning are addressed (1062756; 1012780). The relationship between mental retardation and medical management might be better addressed (1012780).

SA
<table><tr><th>#</th><th>Dx of SA</th><th>Problem</th><th>Interventions</th></tr><tr><td>1044956</td><td>Depend: ETOH, cocaine, MJ</td><td>Y</td><td>Ok</td></tr><tr><td>1029452</td><td>Polysub abuse* (ETOH, cocaine)</td><td>Y</td><td>Ok</td></tr><tr><td>0043568</td><td>Polysub depend</td><td>Y</td><td>Ok</td></tr><tr><td>1081766</td><td>ETOH depend</td><td>Y</td><td>Ok</td></tr><tr><td>LJJ</td><td>ETOH and cocaine</td><td>Y</td><td>None</td></tr></table></td><td>Significant efforts have produced results within the standard of care. Good job!</td></tr>
</table>

	abuse		
1073797	Polysub depend	Y	Ok
1059632	Polysub depend	Y	Ok
1027494	Cocaine and MJ abuse	Y	Ok
Involve patient in identifying goals and objectives (IIIA3)	PC	Quite variable. Difficulties having patient remain in room. The Gero Team was dismissive of the patient, condescending and rude. It was painful for all to watch.	
Involve family/guardian when appropriate (IIIA3)	PC	Little evidence of involvement.	Other NC State Hospitals do better with this and are challenged by more impediments to family involvement.
Reviewed and revised as clinically indicated (IIIA5b)	SC	Treatment Plan Reviews TPR's run the gamut from those that clearly document progress and make changes in interventions to those that are basically useless. If there is no change in behaviors, or in some cases a worsening of behaviors, there needs to be changes in interventions or explanations as to why there are not. Per PI/RM Committee, September 26, 2007 Standard: Treatment Plan Addenda will be written within 10 working days of the patient meeting established threshold. During 4th quarter FY07, 90% completed within 10 working days. This meets JUH standard for this variable of 90% compliance. However, 10 days is much too long for the TP Addenda.	The fact that some of the TPR's actually document progress, changes in goals and changes in interventions is a significant step forward. Re-evaluate the 10-day standard. Some hospitals use "next business day", others use 48 hours or next business day, whichever comes first.
Treatment Plan Content includes Suicide precautions (if appropriate) (IIIB2) Measurable behavioral goals and objectives, i.e., basis for	PC	See section "Individualized."	Further training, mentoring, and practice should move this to compliance.

<table>
<tr>
<td>quantifying progress (IIIA5a)

Emphasis on teaching alternative adaptive behaviors (IIIA6)</td>
<td>SC</td>
<td>Short Term Goals in Groups (Rehab Unit)
<table>
<tr><th>Group</th><th># of patients</th><th>Process goals t/#/# possible in this group</th><th>Content goal t/#/# possible in this group</th></tr>
<tr><td>Self Esteem</td><td>5</td><td>[1 temp assignment]</td><td>4/2</td></tr>
<tr><td>Treatment & Recovery</td><td>8</td><td>4/4</td><td>5/1</td></tr>
<tr><td>Leisure Awareness</td><td>11</td><td>7/7</td><td>4/1</td></tr>
<tr><td>Life Skills (Spanish)</td><td>5</td><td>5/5</td><td>0/0</td></tr>
<tr><td>12-Step</td><td>12</td><td>3/0</td><td>9/9</td></tr>
</table>
</td>
<td>Need to move towards writing content goals specific to each group the patient is in.</td>
</tr>
<tr>
<td>Identified least restrictive interventions (IVC)</td>
<td>C</td>
<td>No evidence that more restrictive or coercive interventions are used than is necessary.</td>
<td></td>
</tr>
<tr>
<td>Explanation of psychopharmacological interventions with particular attention to the prescription of

Benzodiazepines (IIID6)

Antipsychotic medications (IIID6)

Criteria for use of seclusion and/or</td>
<td>C</td>
<td>Psychiatrists are generally including the reasons for use of medication and are generally specifying medication under the STG for which the medication is an intervention.

Benzodiazepines
Total 10 patients
All standing orders
Dosage range 0.5mg to 4.0mg/day</td>
<td></td>
</tr>
</table>

<table>
<tr>
<td>restraint as last resort (IVC)</td>
<td>N/A</td>
<td>Not called for in any MTP reviewed.</td>
<td></td>
</tr>
<tr>
<td>Criteria for release from seclusion and/or restraint (IVF)</td>
<td>N/A</td>
<td>Not called for in any MTP reviewed.</td>
<td></td>
</tr>
<tr>
<td>Education about diagnoses (IIIC2)</td>
<td>SC</td>
<td>Included in individual and group interventions. Part of patients' meetings with Treatment Teams.</td>
<td>When understanding diagnosis appears to be crucial to treatment adherence, this needs to be a more explicit part of the Treatment Plan.</td>
</tr>
<tr>
<td>Skill building for
Problem-solving techniques (IIIC1)

Self-medication skills (IIIC3)

Symptom management (IIIC4)

Cognitive and psycho-social skills (IIIC5)

Moderation or cessation of substance use (if appropriate) (IIIC6)</td>
<td>PC</td>
<td></td>
<td>The greater the use of process STG's, the less the focus on skill. Above, under the Teaching of Alternative Adaptive Behaviors, it is clear that the emphasis is on process STG's. Patients are provided opportunities to practice skills, but inadequate assistance to learn them.</td>
</tr>
<tr>
<td>Medical treatments (routine, preventative, emergency) (VB)</td>
<td>C</td>
<td>See discussion in Assessment Section.</td>
<td></td>
</tr>
<tr>
<td>Transition/Discharge planning that reflects the need for aftercare services (IIIB5c, VIIB1)</td>
<td>SC</td>
<td>See Table 4 (attached).

Discharges

<table>
<tr><th>#</th><th>DOD</th><th>D of FU appt</th></tr>
<tr><td>1083414</td><td>9-21-07</td><td>9-25-07</td></tr>
<tr><td>105441</td><td>9-21-07</td><td>9-24-07</td></tr>
<tr><td>0911059</td><td>9-20-07</td><td>9-21-07</td></tr>
</table>
</td>
<td>Critical Barriers to Discharge for Patients on Rehab Unit 1 Year or Longer – (2006)

<table>
<tr><th>Reason</th><th>Percent</th></tr>
<tr><td>Entitlement/Funding</td><td>42%</td></tr>
<tr><td>Medical/Psychiatric</td><td>19%</td></tr>
<tr><td>Patient/Family</td><td>15%</td></tr>
<tr><td>Legal</td><td>12%</td></tr>
</table>
</td>
</tr>
</table>

		<table><tr><td>0046048</td><td>9-17-07</td><td>9-27-07</td></tr><tr><td>0966483</td><td>9-21-07</td><td>10-3-07 & 9-25-07</td></tr><tr><td>0610773</td><td>9-20-07</td><td>9-28-07</td></tr><tr><td>1083933</td><td>9-20-07</td><td>9-26-07</td></tr><tr><td>1083778</td><td>9-21-07</td><td>9-25-07</td></tr><tr><td>0953698</td><td>9-21-07</td><td>9-24-07</td></tr><tr><td>CS</td><td>9-20-07</td><td>10-1-07</td></tr><tr><td>0990018</td><td>9-21-07</td><td>none</td></tr><tr><td>1083876</td><td>9-21-07</td><td>none</td></tr><tr><td>1083661</td><td>9-21-07</td><td>9-25-07</td></tr><tr><td>1076803</td><td>9-21-07</td><td>9-25-07</td></tr><tr><td>1083807</td><td>9-25-07</td><td>10-1-07</td></tr></table> Mixed results, largely positive; of 15 patients 2 had no follow-up appointment 3 had no follow-up appointment within 1 week 10 had follow-up appointment within 1 week “Aftercare Goals” statements are uniformly useless. They are generic, not individualized, not instructive, contribute virtually nothing to adherence or follow-up. See all patient records in Data Base section.	Housing/Services 12% Data do not allow us to know for how many patients the first appointment was with a psychiatrist. If not, but with intake worker or case manager, how many days later was appointment with psychiatrist? Aftercare referrals should be ensuring an appointment with a psychiatrist in a timely fashion – preferably within one week, but surely within two. If this is not occurring, JUH needs to work with LME’s and/or central office to effect this. Without this, JUH is not fulfilling its discharge responsibilities.

Policies

Item	Compliance	Findings	Comments and Recommendations
Ensure patients with “special needs” are appropriately evaluated, treated and monitored Suicide risk (IIIB4)	*C*	*Seclusion, Restraint and Other Interventive Procedures, Policy I-11, Patients Rights Sec.* *Suicide Precautions, Policy II-16, Patient Care Sec.*	

Self-injurious behaviors MI/MR, MI/SA (IIIB2) Hearing impaired (IIIB6)	*C* *C* *N/A*	*Seclusion, Restraint and Other Interventive Procedures, Policy I-11, Patients Rights Sec.* *See discussion of MR diversion in Assessment section.* *Covered in policy on translation services.* *New relevant P/P's – see Data Base.*	
Reduce the use of forced intramuscular medication that differs from the patient's prescribed oral medication (IIID4b)	*N/A*	*Not in JUH policy.* *Continues in JUH in practice, but not excessively. See patient #s: 926808, 925784, 924720, 919126, 925966, 926915, or 2 PRN's: 925628.*	*While this is included in the Policy Section of the US-NC agreement, it should be a practice parameter not in Policy. The practice should be addressed through CME and peer review. When ordered, by an MD, the rationale for the second (different) medication should be included in the progress note.*
Use of restraints or seclusion (IVA,D)	C	S/R reduction efforts on CPI parallel the efforts to decrease patient-to-patient assaults. Weekly report on S/R use in discipline head committee. No Planned use of restraints without Unit Clinical Director's approval.	
Use of PRN psychotropic medications (IVB)	C	Policy II-39: PRN psychotropic medication shall be ordered for a maximum of 5 consecutive days.	
Individual with health problems are identified, assessed, diagnosed, treated and monitored	*C*	*Documents* *Nursing Service Procedure Manual for physical care of patients (NSPMPCP)* *Nursing Policy Manual* *Nursing Medical Protocols (eleven)* *Nursing Management of Short-Term Physical Problems* *P/P on Aspiration Prevention, Fecal Impaction/Constipation*	

Procedures

Item	Compliance	Findings	Comments and Recommendations
Health problems (identified, assessed, diagnosed, treated and monitored) (VB)	*C*	*Documents* *NSPMPCP* *Nursing Medical Protocols (eleven)* *P/P on Aspiration Prevention, Fecal Impaction/Constipation, Falls* *See sections on Assessments and on Quality Assurance/Performance Improvement.*	
Investigation untoward events, serious injuries, and sentinel events (VIA2)	*C*	*See section on Quality Assurance/Performance Improvement.* *Rather than page through scores of incident reports, I evaluated JUH's process by reviewing two incidents from the occurrence through to the conclusion and outcome of the investigation in two cases with findings of fault. Documents reviewed included, Patient Incident Form, Occurrence Report, Advocacy Investigation Summary, Averse Event/Sentinel Event Management Investigation Report, Outcome, and actions taken. The JUH process is at or above standard for this process.*	
Routinely reviewing incident reports to assess individual or systemic trends or issues exist and changes in treatment are warranted (VIA3) Investigating untoward events, serious injuries, and sentinel events (VIA2)	C		
Routinely reviewing incident reports			

to assess whether individual or systemic trends or issues exist and changes in treatment are warranted (VIA3)			

Practices

Item	Compliance	Findings	Comments and Recommendations
Case formulation (IIID6)	PC	Psychiatric Assessments selected by JUH to demonstrate Formulation (see Data Base – first 9 in list) show marked improvement and are generally quite good. A review of the Psychiatric Assessment of the last 15 admissions show that 14/15 do not meet the standard of an adequate formulation. Of the 15, 4 were done by residents, 11 by staff psychiatrists. The only one that met standard was a CPI case done by a resident.	Improvement clearly possible, but psychiatrists are not routinely performing up to their capacity.
Monitored, documented, and reviewed by qualified staff (IIID1) Use of anti-psychotics	*C*	*Explained in Patient Care Policy II-9* *Antipsychotic medications are prescribed by psychiatrists (a stat dose, may be ordered in an emergency by a non-psychiatric physician) administered by RN's or LPN's without exception. No evidence of antipsychotic medication used for behavior control in the absence of appropriate Axis I diagnoses. Occasional evidence of continuance of antipsychotic medication used in outpatient setting when admitted and there is inadequate evidence for antipsychotic medication, e.g., #1015192.* *Antipsychotic medication blood levels appear to be used appropriately. There was no evidence any form of special authorization was required to obtain these levels.*	

Medication combinations	*C*	*AAU: 13 or 87 (15%) of patients taking antipsychotic medication of more than one type. Of these, 7 on one atypical and one typical, 4 on two atypicals; one on two atypicals and one typical; and 1 on one atypical plus PRN typical.* *Gero: 3 patients on more than one antipsychotic, 2 on one atypical and one typical; 1 on two atypicals.* *Other units: none* *Polypharmacy: A review of twelve records, specifically chosen from the January 18, 2007 population data for use of polypharm showed either 1) the elimination of polypharmacy or 2) the justification for polypharmacy. Almost without exception, documentation by Attending Psychiatrists of their psychopharmacologic management of their patients was from adequate to excellent. See #076354, #1068381, #0389567, #1043945, #0953142, #0987422, #1072660, #0997649, #1063422, #1012780, #0380281, #0039011.*	
Pro re nata (PRN) and STAT orders (IIID2)	SC	STAT Medication August 18-31, 2007 6 doses in this two-week period 5/6 with adequate documentation October 14-20 8 doses in this one-week period 4/8 with adequate documentation PRN medication is quite commonly ordered. Ordered doesn't mean given, but the ordering of PRN's is high, particularly when contrasted with CH, which has a no PRN policy. For the week of October 14-20, the PRN orders were: Meds* No. of Patients** Benzodiazepine 65	

<table>
<tr>
<td></td>
<td></td>
<td>Benzodiazepine + Antipsychotic 20
Antipsychotic 22
Hypnotic 5
Hypnotic + Benzodiazepine 2
Trazodone 9
Trazodone + Benzodiazepine 1
TOTAL 124
*All orders comply with 5-day or less time limit.
**When patient received multiple orders during this one week for any PRN medication, all orders for the same medication were only counted once.</td>
<td></td>
</tr>
<tr>
<td>Intramuscular injections (IIID5)</td>
<td>C</td>
<td>IM for long acting antipsychotic medication
AAU: 3 haloperidol decanoate, 1 fluphenazine decanoate, 5 risperidone consta
Rehab: 1 haloperidol decanoate, 4 fluphenazine decanoate, 2 risperidone consta
IM for behavioral control
AAU: 3 patients on PRN haloperidol plus lorazepam, 6 patients on benzodiazepine, 1 patient on ziprasidone</td>
<td>Use of long-acting medications show selection across three available forms=individuation. Use of IM forms to address compliance.

No evidence of overuse or misuses of IM back-up to PO refusal for PRN's. Number is low and does not reflect what can be routine practice in some facilities of always writing an IM back-up for a PO order for behavioral control.</td>
</tr>
<tr>
<td>Benzodiazepines (IIID2)</td>
<td>PC</td>
<td>See Documentation Section below.</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>PC</td>
<td>Seclusion and Restraint Rates, January 2000-July 2007:
<table>
<tr><td>Seclusion</td><td>Child

Increase trend. Usage per 1000 patient days in 2007 about 100% higher than 2000.</td><td>Adult

Flat line at about 0.</td></tr>
<tr><td>Restraint</td><td>Decreasing</td><td>Decreasing</td></tr>
</table></td>
<td>Need to work on seclusion usage on CPI.</td>
</tr>
</table>

				trend. Usage per 1000 patient days in 2007 about 40% of rate in 2000.	trend. Usage per 1000 patient days in 2007 about 50% of rate in 2000.	
			Restraint and Seclusion	Together, there is little change	Substantial decrease.	

Protocols

Item	Compliance	Findings	Comments and Recommendations
Nursing protocols for medical care and treatment (VC)	*C*	*Available for: 1) aspiration pneumonia; 2) care of patients in cast; 3) deuoderm; 4) emergency treatment of hypoglycemia; 5) falls precautions; 6) fecal impaction; 7) G, J, NG tube site cave; 8) impaired skin integrity in perineum; 9) initial care of burns; 10) minor skin abrasions; 11) superpubic catheter care.*	
Nursing protocols to ensure that patients are appropriately supervised and monitored (VIB2)	*C*	*Nursing service Standard of Care III: establishes clear lines of authority, responsibility, accountability. Appropriately references suicide precautions, R/S, medication errors, documentation.* *Nursing Policy Manual: Patient Care Assignments; 1:1 or 2:1 Patient Level of Observation Levels (this is quite inclusive absent recommendation); Accounting for Patients (patient counts).*	*1:1 or 2:1 Patient Observation Levels should include a #10 indicating how this level is ended, and nursing staff are relieved of this responsibility.*

Plans

Item	Compliance	Findings	Comments and Recommendations
Appropriate evacuation plans (VIB3)	*C*	*Per Emergency Management Plan (3-15-06) see sections: Partial Evacuation Plan, Off-campus Evacuation Plan and Components of Safety and Security Officer duties.*	

Physical Plant

Item	Compliance	Findings	Comments Recommendations
Modifications for hearing impaired (IIIB6)	*C*	*Barrett building with horn-strobe fire alarm system.* *TDD phone (mobile) can be used on any unit.* *Contract in place for interpreter services.* *Televisions can be set for hearing impaired screen option.*	
Eliminate to a reasonable degree all suicide hazards in patient bedrooms and bathrooms (VIB1)	C	Hanging Risks Ward 324 Bathroom: plumbing, handicap rails, stall doors, stall door handles, scale chair, stall wall attachments, mounted emergency call switches, shower handles, shower faucets, tub plumbing Ward 491 Bathroom: stall half wall, sink faucets and spouts, main door handle Shower: faucet, bench, plumbing, closet door knobs, closet door latch Ward 453 Bathroom: handicap rails, faucet next to toilet, stall walls, stall doors, sink faucets, sink spout, broken toilet paper chain, door hinge on outer door (inside hinge) Shower: faucets, bench, handicap shower, soap dispenser, sink plumbing, sink faucets, sink spout, closet door knobs AAU Bathroom: sink faucet, door handle x 2, shower safety bar, shower handle	Physical Plant Unannounced physical environment inspections (ENVIRO Rounds) are conducted at least once every six months in patient care areas and at least once per year in non-patient care areas. The ENVIRO Team consists of representatives from Safety, Environmental Services, Risk Management, Plant Operations, Infection Control and Engineering. Written reports which include deficiencies identified during the inspection are compiled and sent to Unit/Department Managers for follow-up. The written report is also forwarded to Plant Operations in order to enter Work Orders for each maintenance item. The findings from the ENVIRO Rounds are reviewed by the Safety Committee. Inspections for safety hazards in the physical environment are also conducted quarterly in each Unit/Department and are the responsibility of Unit/Department Heads. These written reports are submitted to the Safety Officer for review and are reported quarterly to the PI/RM and Safety Committees.

		Newly modified policy addresses these risks: Life Safety Rounds: Staff member(s) will be assigned to perform visual checks of the following areas: All patient bathrooms and patient showers. These areas are to be inspected by the assigned staff member for safe use by the patients. The staff member will utilize a worksheet that indicates by initials these areas are safe for the patient to use. Life Safety Rounds are conducted every 30 minutes. The charge RN will indicate on the ward shift assignment who is assigned these tasks and at what times they are to perform the safety rounds.	Inspections appear to be appropriately done. Work orders when needed. Follow-up not in information provided to me.

Staff Training

Item	Compliance	Findings	Comments and Recommendations
Writing behavioral goals and objectives (IIIA3)	*C*	*JUH identified facilitators for each treatment team and facilitators were trained in 9/06. JUH also instituted a Quality Review Committee in 11/06 for senior clinical staff to review one MTP per team per month with findings shared with Treatment Team Leaders. A summary of my observations from technical assistance visits in 10/06 and 11/06 were sent to clinical staff for training purposes. Each clinical department head has provided focused training with their staff on writing goals and interventions during 1/07 meetings.* *Also Grand Rounds February 1, 2007.*	*Continue current mentoring and monitoring to improve outcomes.*
Serving the needs of patients requiring specialized care (suicide risk (IIIB4)), SIB, MI/MR, MI/SA (IIIB2), Hearing impaired (IIIB6)		Behavior Support Plans for MR patients. Documents reviewed included: 1012780 (Schizoaffective, Mild MR): Behavioral Assessment, Behavioral Support Plan, documentation of Behavior Plan inservice training, procedure for grooming training, post-intervention data 1062756 (ADHD, Mod MR): Initial	Use outside consultation from Murdock Center with greater frequency.

		Psychological Evaluation, Behavioral Assessment, Behavioral Support Plan, documentation of Behavior Plan inservice training, prototype data sheets, post-intervention data The Behavioral Assessments demonstrate more complete data collection, better functional analysis of behavior, antecedents and consequences. Not clear plans will shape behavior and then allow for generalization. Process is significantly improved.	
Risks and side effects in administering benzodiazepines	C	See Staff Training section in Data Base.	
Risks and side effects in administering antipsychotic medication	*C*	*Many examples throughout 2006 of education for physicians, nurses. Included staff development curriculum.*	*Continue including intermittently in Grand Rounds.*

Specific Documentation Requirements

Item	Compliance	Findings	Comments and Recommendations
Behavioral goals and objectives which include, when possible, patient and family input (IIIA3)	C		These parameters are being documented.
Treatment plans shall reflect an interdisciplinary process based upon reliable objective data and clearly established measurable goals (IIIA5a)	PC	Each unit (except AAU, ADATC) of the hospital has specific plans to address assaults – see Data Base, QA/PI under Assaults. Increased use of behavioral assessments, behavioral interventions, and formal behavioral support plans hospital-wide – see Data Base, Behavioral Consultations. CPI Behavioral Specialist on the task. He was observed doing an observation/data collection 10-18-07. High incidence time identified on CPI (2:00 p.m.) and addressed through RT interventions. On CPI, modification of programming for	Major gains, but documentation of **measurable** goals is holding JUH back in many areas.

		Restriction Track children on the weekends. On CPI, in process of revision of points and levels system focused on skills development rather than compliance. Draft Philosophy and guidelines developed – see Data Base. Gero Unit has sensitized nursing staff to peak hours when assaults occur (data analysis) and is examining impact of mall hour changes that went into effect August 2007. JUH's own analysis (PIP, staff effectiveness, January-June 2007) shows a statistically significant positive correlation between census and patient-on-staff assaults on CPI and on AAU. Hence, another reason to strive to manage inpatient census. Documentation that high census is dangerous.	
Use of all medications (IIID1)	SC	See Table 5 (attached).	Providing rationales for medication changes seems on my chart review to be a more significant problem than it appears to be from JUH's own monitoring. However, even the 4th quarter (FY07) compliance of 83% is low when acceptable standards must be 100%. I concur with Dr. Oxley's concern about this (PI/RM Committee Meeting Minutes, September 12, 2007). None-the-less, major improvements noted.
Identify the symptoms and/or behavioral problem and tie to justification for the use of any antipsychotic medication or benzodiazepines (IIID4)	PC	Benzodiazepine usage neither adequately documented nor adequately accounted for. See 015211 8-22-07 to 9-26-07 005008 Diazepam on admission 0985267 Lorazepam 1083989 Lorazepam 10-16-07 0952547 PRN Lorazepam 9-26-07, 10-17-07 0270922 PRN Lorazepam 10-11-07 0906577 PRN Lorazepam on admission	Medication Documentation Psychiatric Assessments most often list medications without explaining the medications. Preadmission Medication List and Physician Order (one document) has column heading: "Rationale for Medication or for Stopping It." This column is often 1) blank; 2) filled in with generic statement like "depression", "mood"; 3) completed for antipsychotic medication with no explanation of why more than one.
Clearly document behavioral issue(s) and tie to justification for use of	*NA in part*	*See Practices Section.*	

intramuscular medication (IIID5a)			
Use of restraints and seclusion documented and reviewed in a timely fashion by qualified staff (IVE)	*C*	*Documentation of appropriate use of seclusion or restraint (restraint and seclusion use forbidden) in terms of:* *RN initial assessment efforts at less restrictive/intrusive interventions* *timely MD assessment* *timely MD orders* *reassessments by RN, MD as required* *monitoring and documentation of patient during restrictive intervention* *release at earliest clinically appropriate time debriefing* *were consistently found, as shown by #1068381, #1077066 (manual hold only, restraint avoided), #0049794, #0049794.* *When patient met threshold to trigger a TPR based on use of S/R, there was evidence of notification to team by Clinical Director and completion of TPR within required 10 working days – see #0049794.* *The use of restraints for medical purposes was rare, clinically appropriate, had doctors' orders as required, and monitored as evidenced by #1063422.*	
Criteria for release from restraints and seclusion clearly identified and written in patient's treatment plan (IVC)	N/A	This does not appear in Treatment Plans, nor can it. Criteria will vary depending on patient's clinical condition at the time with a set of general guidelines. The documentation should be the patient's preferred method for restrictive interventions and for soothing/de-escalating interventions. There are hints of this present on the Treatment Plans.	
Provisions of nursing and medical care (VD)	*C*	*See Assessment Section.*	

Quality Assurance and Performance Improvement

Item	Compliance	Findings	Comments and Recommendations
Detect timely and adequately problems with the provision of protections, treatment, services and supports and to ensure that appropriate corrective actions are implemented (VIA1)	*C*	*Per Policies:* *Risk Management Reporting, Patient Care II-20* *Patient Incidents/Occurrences, Patient Care II-21* *Adverse Event, Patient Care II-22* *Sentinel Events, Patient Care II-23* *These P/P's and others appropriately direct hospital staff as to what they must do as follows:* *The JUH Performance Improvement/Risk Management Program Manual was reviewed. JUH staff is trained in incident reporting upon hire in Hospital Orientation. JUH staff complete incident reports to record unusual incidents as well as seclusion and restraint episodes. The completed incident reports are given to the patient advocates for review daily. The advocates then deliver them to the QM department for data entry. The QM department enters the data and generates monthly printouts on a variety of incidents (UAs, falls, major injuries, etc.) and seclusion and restraint episodes. These are sent to Unit Management Teams for review to identify trends and improvement strategies. QM department staff (PI and RM staff) utilizes numerous queries from the QM database to complete quarterly PI or RM reports that are presented to and reviewed by the JUH PI/RM Committee, which includes all members of the JUH Executive Team, the President of the Medical Staff, and other clinical department heads. This Committee reviews reports to address trends, requests drilling down of data to identify other contributing factors, and makes requests for*	*PI programs on Behavior Plans, and on Treatment Plans need to be reviewed and revised. As constructed, the data collected does not adequately address the indicator.* *Data on PI program on Treatment Plans needs to be reviewed for validity and rehability. Outcome of 100% for STG's are observable/measurable seems doubtful.* *For the active treatment PI program what is the definition of "active treatment"?* *See above.*
Actively collecting data relating to the quality of nursing and medical services (VIA1a)			
Assessing data for trends (VIA1d)	*C*		

		additional information or charges relevant departments/services to develop improvement strategies. In addition to hospital-wide PI and RM indicators, all units and departments, e.g., nursing also identify and report on performance improvement or quality control indicators. All unit and department indicator reports are also presented to the hospital's PI/RM Committee. *JUH Committees (both hospital and medical staff committees) also review data on a routine basis during their monthly committee meetings (CPR/Code Blue Committee, P&T Committee, Infection Control Committee, Safety Committee, etc.). The identified trends and recommended improvement strategies are reported at Medical Staff meetings and at the PI/RM Committee meetings.* *The list of all JUH PI/QA indicators and RM indicators were reviewed and found to be appropriate. Examples of this process were reviewed in the form of the Quarterly Indicator Report:* - *PI: Implementation of Behavior Plans will improve the patient's functioning and progress towards achieving their treatment goal.* - *PI: Treatment Plan Addenda will be written within 10 working days of patient meeting individual threshold.* - *Documentation requirements will be met according to the criteria in JUH's seclusion and restraint policy.* - *PI: Treatment Plans will be individualized, problem-focused and interdisciplinary.* - *PI: JUH will provide patients with an average of 20 hours of active treatment*	

		each week. - *PI: Rationales for medication changes will be documented in the patient's medical record.* - *PI: Documented rationales will be provided for patients on two or more antipsychotic medications.* - *RM: Patient falls and falls with major injury will be reported, investigated, trended.* - *RM: Patient injuries related to patient assaults will be reduced.* - *RM: Major injuries will be reviewed for trending and for comparison with ORYX.* - *Medical Staff: risperidone consta study; identifying and communicating about high risk (medically) patients; timeliness of referrals for medical services.* - *Nursing: med administration (4 indicators); patient safety and appropriate care (5 indicators); patients' rights (13 indicators); patient care and safety (1 indicator)* - *Unit: Code Blue, EEG completion, antibiotic within 4 hours of MSU admission, use of Kardex, increased presence of RN's and HCT's at CPI IDT meetings* Complaints NC/DHHS/DFS/MHLCS investigated complaints as follows: February 4 March 4 April 2 June 2 None of the 12 complaints were substantiated.	
Initiating inquiring regarding problematic trends and possible	C		

deficiencies (VIA1c)			
Identifying corrective action (VIA1d)	C		
Monitoring to ensure appropriate remedies achieved (VIA1e)	C		
Conducting adequate mortality reviews to ascertain the root causes for all unexpected deaths (VIA4)	*C*	*There were three deaths, July 1, 2006-February 12, 2007. MSU Death Review Committee minutes examined. Root cause analysis for two deaths that had root cause analysis reviewed. All standards met.*	
System to oversee discharge process (VIIB3)	C	System to oversee discharge process – Audit one chart per SW per month. Ten items on audit specifically address discharge. – SW supervision specifically addresses discharge. Unit SW supervisor meets individually with Unit SW's monthly. – Unit SW Supervisor has meeting with Unit SW's twice per month. – Director of SW has individual meeting with each SW supervisor twice per month. Group meeting twice per month. – Patients discharged with one week of pills and script for one month. Rehab Unit Discharges (Average per Month) 2004 4 2005 5.5 2006 6 2007 (Jan-Aug) 8 This is showing a quite positive trend.	

Communication

Item	Compliance	Findings	Comments and Recommendations
Physician orders for enhanced supervision be communicated to appropriate staff (IIIB4b)	C		
Treatment team members communicate and collaborate effectively (IIID7)	PC	Hospital Wide Patient to Patient Assault Rate shows a troubling trend. From January 2001-August 2007 there is a progressive increase from 1-2 per month in 2001 to 3-9 per month in 2007. Graphing this produces an upward slope from one (1) in 2001 to 5+ in 2007.	Extreme variation. Compliance really runs from NC to SC depending on the Team.
Adequate and appropriate interdisciplinary communication among relevant professionals (VE, VI)	PC	PSR Group Notes – Gero Goal is communicated to Group Leader Notes very often provide information relevant to goal and other information. Why do all groups for a given patient have the same goal? PSR Group Notes – Rehab TX Mall Progress notes almost uniformly do <u>not</u> address goals. Sometimes goal could not possibly be addressed in the group, i.e., context in which the goal could be achieved is not this group.	

Staffing Requirements

Item	Compliance	Findings	Comments and Recommendations
Ensure a sufficient number of qualified staff to supervise suicidal patients (IIIB4b)	*C*	*1:1 staffing was consistently found on tour when it was ordered. Additional staff were provided for specialing.*	
Hire and deploy sufficient number of qualified direct care and professional staff, particularly psychiatrists and nurses, necessary to provide patients	SC	See Table 6 (attached). Days or Part Thereof Waiting List in Effect Feb (10-28)0 March 3	Concern that when JUH is at 110% census – these days the Waiting List is in effect – there are *de facto* staff shortages in all disciplines except nursing which can flex up or down staff present based on census and acuity.

with adequate supervision and medical and mental health treatment (VA)		April 1 May 6 June 6 July 3 August 3 September (1-10) 5 Total days 27 Percent of Days 13% Psychiatry caseloads are quite reasonable. For these, see table 7.	

If you should have any questions about this report, please feel free to contact me by telephone at 508-856-6527, by fax at 508-856-3270, or via email at jeffrey.geller@umassmed.edu.

Respectfully submitted,

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JG:vab